STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES
-

Medical Facilities Unit – Acute Care

Home Health Care Services Agency

SECTION 1: Agency Information			
Agency Name:			
Doing Business As:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:			

SECTION 2: Fees	
APPLICATION FOR HOME HEALTH CARE SERVICES AGENCY	
License Type: ☐ Initial Application (fee $300) ☐ Renewal Application (fee $300) License Renewal Period (dates): _____ to _____	 $ _____ $ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Checks/Money Orders enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Regulatory Services
Medical Facilities – Acute Care Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: DLRS.MedFacilities@maine.gov

Office Use Only:
Check# _____ MO # _____ Amount $_____ Initials: _____ License# _____

SECTION 3: Ownership Information (Use additional sheets, if necessary)

Type of Entity:

☐ Sole Proprietorship (complete section A)

☐ Partnership (complete section B)

☐ Other: _____

☐ Corporation (complete section C)

☐ Not-for-Profit (complete section D)

A. Sole Proprietorship

Owner Name:			
Mailing Address:			
City:	State:	Zip:	County:
Telephone No.: ( )	ID# (Owner SSN or EIN#):		

B. Partnership

List the names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

Name	Address
_____	_____
_____	_____
_____	_____
_____	_____

C. Corporation

List the names, address and titles of the Officers and Directors.

Officer Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Director Name	Title	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Not-for-Profit

List the name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name Address

_____ _____

_____ _____

SECTION 4: Facility Information (Use additional sheets, if necessary)

Name of Person in Charge:		Title:	
Home Address:			
City:	State:	Zip:	County:
Home Telephone No.: ( )		Office Telephone No.: ( )	

Home Health Care Service Operation Date:

Date that this program has been open since: _____

Date that this program is scheduled to open: _____

Geographic Area Served: _____

Location of all facilities (specify sub-units, branches, or drop sites) utilized by the Home Health Care Service Provider:

Name of Owner of Building Address
Telephone Number

1. _____ _____
   _____ _____
2. _____ _____
   _____ _____
3. _____ _____
   _____ _____

Services Provided: Please select all that apply and indicate when each service was started.

☐ Skilled Nursing	_____	☐ Medical Social Work	_____
☐ Speech Pathology	_____	☐ Home Health Aide	_____
☐ Physical Therapy Services	_____	☐ Certified Nursing Assistant	_____
☐ Occupational Therapy Services	_____	☐ Other: _____	_____

Full-Time Equivalent Staff: All employees of the Home Health Care Service Provider, including administrative, business, clerical and direct service providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37 ½ hours per week for the hospice agency. Both individuals directly employed and those contracted by the agency shall be counted in the calculation of the agency's full-time equivalency figure.

How many full-time equivalent staff are employed by the agency? _____

Name of Director of Nursing: _____

Accreditation: Please select all Accreditation Organizations that this Hospice Program is accredited by.

☐ Joint Commission ☐ CHAPS ☐ Other: _____

☐ Federal Deemed Status Dates: _____

Directions to the Agency: Please be specific; draw/provide a map if possible.

_____

_____

_____

_____

_____

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of any and all leases, if the building(s) used is leased.
- Letter(s) from the appropriate Municipal Official(s) that demonstrates compliance with all Local Ordinances relative to zoning and building code regulations. Applicable for Initial applicants or if you have moved since your last renewal.

In addition, first time applicants must also submit:

- Financial Feasibility Plan, to include, two (2) year projection of operating and non-operating expenses; evidence of the availability of financing to include cash flow, salaries, etc.
- Marketing Plan, to include, a description of the market area, size of the market and estimated growth, estimate of potential clients and competitors.

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the agency herein described, do hereby apply for a license to operate the agency and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA Chapter 1681, Sections 8621-8631.

_____	_____	_____
Print name of Administrator	**Signature of Administrator**	**Date**